State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

REGISTRATION OF MEDICAL EQUIPMENT

Public Chapter 780, Acts of 2002, requires that owners of the following medical equipment with the Tennessee Health Services and Development Agency: computerized axial tomographers, lithotripters, magnetic resonance imagers, linear accelerators, and positron emission tomography. Registration should occur within 90 days of acquisition.

Should you wish to provide information not specifically requested or further information with regard to information reported, please attach a separate page to provide such narrative.

□ **Correct As Is** □ **Correction** □ **Equipment Replace/Upgrade**

□ **New Facility with Equipment** □ **Add Equipment**

1. NAME AND ADDRESS OF PROVIDER

(Name)

(Street Address) (County)

(Mailing Address, if different from Street Address)

(City) (State) (Zip) (Telephone Number)

Type of Provider:

□ ASTC □ Hospital □ Hospital Imaging Department (off site) □ ODC

□ Physician's Office □ Other (specify) _____

2. NAME AND ADDRESS OF OWNER OF HEALTH CARE PROVIDER

(Name)

(Mailing Address)

(City) (State) (Zip) (Telephone Number)

3. CONTACT PERSON *(Responsible for registration and utilization requests)*

(Name) (Title)

(Company) (Email Address)

(Mailing Address) (Telephone Number)

(City) (State) (Zip) (Fax Number)

4. EQUIPMENT OWNERSHIP INFORMATION

NOTE: Before you begin – the information below is required for each piece of equipment. If you have two or more of the same type of equipment, please copy this page for each, complete, and attach all pages to the first page of the Registration Form.

A. CT:

□ Owned □ Leased □ Shared □ Fixed Site □ Mobile (Full) □ Mobile (Part)

□ Number of Mobile/Shared Days in Use: _____ Days Per _____ (week,month,etc.)

Shared With and/or Leased By: _____

Date Acquired: _____ Name Brand: _____

Initial Cost: _____ Serial No.: _____

Expected Useful Life (Yrs): _____ Assigned No.: _____

Scanner Type: □ 4 Slice □ 16 Slice □ 40 Slice □ 64 Slice □ Other _____

B. Cyberknife/Gamma Knife/Proton Therapy:

(Check appropriate equipment) □ Cyberknife □ Gamma Knife □ Proton Therapy

□ Owned □ Leased □ Shared □ Fixed Site

Shared With and/or Leased By: _____

Date Acquired: _____ Name Brand: _____

Initial Cost: _____ Serial No.: _____

Expected Useful Life (Yrs): _____ Assigned No.: _____

C. Linear Accelerator:

□ Owned □ Leased □ Shared □ Fixed Site

Shared With and/or Leased By: _____

Date Acquired: _____ Name Brand: _____

Initial Cost: _____ Serial No.: _____

Expected Useful Life (Yrs): _____ Assigned No.: _____

□ MeV: _____ □ Single Energy □ Dual Energy □ Photon □ Photon Electron

Special Types: □ SRS □ IMRT □ IGRT □ Other _____

D. Lithotripter:

□ Owned □ Leased □ Shared □ Fixed Site □ Mobile (Full) □ Mobile (Part)

□ Number of Mobile/Shared Days in Use: _____ Days Per _____ (week,month,etc.)

Shared With and/or Leased By: _____

Date Acquired: _____ Name Brand: _____

Initial Cost: _____ Serial No.: _____

Expected Useful Life (Yrs): _____ Assigned No.: _____

□ Stored in Closet Until Needed □ Transported Room to Room (Full Time Equipment Only)

E. MRI:

□ Owned □ Leased □ Shared □ Fixed Site □ Mobile (Full) □ Mobile (Part)

□ Number of Mobile/Shared Days in Use: _____ Days Per _____ (week,month,etc.)

Shared With and/or Leased By: _____

Date Acquired: _____ Name Brand: _____

Initial Cost: _____ Serial No.: _____

Expected Useful Life (Yrs): _____ Assigned No.: _____

Tesla Strength: □ 0.2 □ 0.5 □ 0.7 □ 1.0 □ 1.5 □ 3.0 □ Other _____

Magnet Type: □ Breast □ Closed □ Extremity □ Open □ Short Bore □ Other _____

F. PET:

□ Owned □ Leased □ Shared □ Fixed Site □ Mobile (Full) □ Mobile (Part)

□ Number of Mobile/Shared Days in Use: _____ Days Per _____ (week,month,etc.)

Shared With and/or Leased By: _____

Date Acquired: _____ Name Brand: _____

Initial Cost: _____ Serial No.: _____

Expected Useful Life (Yrs): _____ Assigned No.: _____

Scanner Type: □ PET Only □ PET/CT Combination □ PET/MRI Combination

G. Other:

□ Owned □ Leased □ Shared □ Fixed Site □ Mobile (Full) □ Mobile (Part)

□ Number of Mobile/Shared Days in Use: _____ Days Per _____ (week,month,etc.)

Shared With and/or Leased By: _____

Date Acquired: _____ Name Brand: _____

Initial Cost: _____ Serial No.: _____

Expected Useful Life (Yrs): _____ Assigned No.: _____

Equipment Description: _____

I hereby certify that this information is true to the best of my knowledge, information and belief, and that supplemental written notification will be filed with the Tennessee Health Services and Development Agency in the event of any change in the information given in this report.

_____ _____

Signature Date